FREDERICK COUNTY HEALTH DEPARTMENT
INTAKE QUESTIONNAIRE

Name of Client: _____ School/Grade: _____

Date: _____ Religion: _____

Race/Ethnic Identification:

Are you of Hispanic or Latino origin? _____ Yes _____ No

Select one or more of the following categories:

___ American Indian or Alaskan Native ___ Asian ___ Black or African American

___ Native Hawaiian or other Pacific Islander ___ White

Date of Birth: _____ Male/Female _____

Who referred you for services?: _____

Reason for Referral: _____

_____

_____

Are you involved with: ☐ Social Services ☐ Juvenile Services ☐ CASS ☐ Health Dept.
(please circle)

Other _____

Presenting Problem: (Give specific examples of the problem) _____

_____

_____

_____

What have you as a family tried in resolving current presenting problems: _____

_____

_____

_____

What goals do you have for treatment?: _____

_____

_____

FAMILY HISTORY

Mother: _____ D.O.B. _____

Father: _____ D.O.B. _____

Sisters/Brothers: _____ D.O.B. _____
_____ D.O.B. _____
_____ D.O.B. _____
_____ D.O.B. _____
_____ D.O.B. _____

Who currently lives in your household? _____

_____

_____

_____

Write a summary of your family's history. Include any information that you feel impacts on the issues you are currently coming to treatment for. (if additional space is needed use the back.)

_____

_____

_____

_____

_____

Family Medical/Psychiatric History (Include immediate and extended family, hospitalizations, medication, etc.):

_____

_____

_____

Has your child/teen received any psychiatric services and if so, where and when? (Include therapy, hospitalizations, medication, etc.):

RELATIONSHIP INFORMATION

On the scale, please circle the quality of this child or teen's relationship with each of the following:

	Terrible	Poor	Fair	Good	Excellent
Mother	1	2	3	4	5
Father	1	2	3	4	5
Step-mother	1	2	3	4	5
Step-father	1	2	3	4	5
Siblings	1	2	3	4	5
_____	1	2	3	4	5
_____	1	2	3	4	5
_____	1	2	3	4	5
_____	1	2	3	4	5
_____	1	2	3	4	5
_____	1	2	3	4	5
_____	1	2	3	4	5
_____	1	2	3	4	5
_____	1	2	3	4	5
Significant Other					
_____	1	2	3	4	5
_____	1	2	3	4	5
_____	1	2	3	4	5
_____	1	2	3	4	5
_____	1	2	3	4	5
_____	1	2	3	4	5

Please summarize problems and/or strengths in relationships as identified on the above scale.

Please list individuals, groups, organizations, which have been enjoyable and/or supportive to you and your child: _____

DEVELOPMENTAL HISTORY

Pregnancy History

_____ Age at time of pregnancy _____ Planned _____ Unplanned

Did you have any health problems during your pregnancy, if so, explain:

Medications or drugs/alcohol taken during pregnancy. Please list below.

Birth History

Type of Delivery: _____ Cesarean _____ Breech _____ Premature _____ Vaginal
Describe any complications during or after delivery: _____

Length of time in labor: _____

Birth Weight: _____

Preschool Developmental Milestones

Please circle type of feeding method: Bottle Breast

Comments regarding any issues related to feeding: _____

How would you best describe your infant/young child's mood/behavior?: _____

Please check and comment on anything during the developmental milestones listed below which you recall as unusual.

_____ Crawling _____ Walking _____ Bladder Trained
_____ Standing _____ Speech _____ Bowel Trained

Comments

EDUCATIONAL HISTORY

Please circle a numerical ranking of your child's adjustment to school: 1 being poor and 5 excellent

Nursery School/Kindergarten	1	2	3	4	5
Elementary School	1	2	3	4	5
Middle School	1	2	3	4	5
High School	1	2	3	4	5

Has your child/teen ever skipped or repeated a grade:_____

Attitude Toward School (Current)	1	2	3	4	5

Current Grades: _____

Please circle current level of services:

Spec. Ed. Directed Honors Merit

Special Education History

Has your child been diagnosed by the school or other health/education professional with the following:

_____ Learning Disability _____ Dyslexia

_____ Speech Development Problems _____ Received special education services past or present

_____ Attention Deficit Hyperactivity Disorder

Comments

_____

_____

EMPLOYMENT HISTORY

Has your teen ever been employed?:
_____

If so, where and when?:
_____

_____

Future Career Plans:
_____

_____

ALCOHOL AND NONPRESCRIPTIVE DRUG USE

	YES/NO/?	AMOUNT	FREQUENCY	LAST USE
Alcohol				
Tobacco				
Caffeine				
Marijuana				
LSD; Hallucinogens				
PCP				
Pain Medications				
Heroin				
Cocaine/Crack				
Methadone				
Inhalants/Solvents				
Over the counter drugs				
Other				

OTHER CONCERNS

Please check and circle all that apply to your child/teen and comment on those checked below.

_____ Sad/Depressed/Frequent crying
_____ Suicidal
_____ Self Destructive
_____ Nervous/Anxious
_____ Weight Gain or Loss
_____ Appetite Problems
_____ Sleep Difficulties
_____ Physical/Sexual/Emotional/Abuse
_____ Fainting
_____ Loss of memory
_____ Frequent Daydreaming/Inattention
_____ Violent Behavior
_____ Temper Outbursts
_____ Cruelty to animals
_____ Fire Setting
_____ Lying/Stealing
_____ Attention Span Problems
_____ High Activity Level
_____ Bedwetting/Daytime
_____ Bowel Difficulties
_____ Seizures/Head Injury

Comments